CHAPTER II - INTERMEDIARY COVERAGE AND RELATED ISSUES FOR THE AMBULANCE FEE SCHEDULE

OBJECTIVE

The objective of the Coverage and Related Issues chapter is to provide information on coverage criteria related to the ambulance fee schedule.

Participants will learn about the following in the course of this chapter:

1. Medicare coverage requirements for ambulance services.

2. New aspects of coverage related to the ambulance fee schedule.

COVERAGE REQUIREMENTS

Many of the Medicare coverage requirements for ambulance services have not changed under the ambulance fee schedule. All of the requirements are included in the following instructions:

Medicare Intermediary Manual, Pub. 13-3, Section 3114 and Section 3322
Program Memorandum AB-99-94
Program Memorandum AB-01-185
Program Memorandum AB-00-103
Federal Register, Vol. 67, No. 39, 2/27/02, 9100-9135
42 CFR 410.40

CATEGORIES OF SERVICE

Categories of Service

1. **Basic Life Support (BLS)**
2. **BLS-Emergency**
3. **Advanced Life Support Level 1 (ALS1)**
4. **ALS Level 1-Emergency (ALS1-E)**
5. **ALS Level 2**
6. **Specialty Care Transport (SCT)**
7. **Paramedic Intercept (PI)**
8. **Fixed Wing Air Ambulance (FW)**
9. **Rotary Wing Air Ambulance (RW)**

The new ambulance fee schedule has seven categories of ground (land or water) ambulance services and two categories of air ambulance services. Paramedic intercept, advanced life support level 2, fixed wing air ambulance, and rotary wing air ambulance assume an emergency condition.

Basic Life Support (BLS)

Basic life support (BLS) means transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from State to State. For example, only in some States is an EMT-Basic permitted to operate limited equipment on board the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

Basic Life Support – Emergency

The Basic Life Support – Emergency category is the provision of BLS services, as specified above, in the context of an emergency response.

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance provider begins as quickly as possible to take the steps necessary to respond to the call.

Advanced Life Support, Level 1 (ALS1)

Advanced life support, level 1 (ALS1) means transportation by ground ambulance vehicle, medically necessary supplies and services and an ALS assessment by ALS personnel or the provision of at least one ALS intervention.

Advanced life support assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

Advanced life support intervention means a procedure that is, in accordance with State and local laws, beyond the scope of authority of an emergency medical technician-basic (EMT-Basic).

Advanced life support personnel means an individual trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic. The EMT-Intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT-Basic and who is also qualified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications. The EMT-Paramedic is defined as possessing the qualifications of the EMT-Intermediate and also, in accordance with State and local laws, as having enhanced skills that include being able to administer additional interventions and medications.

Advanced Life Support, Level 1 – (ALS1) Emergency

The Advanced Life Support, Level 1 – Emergency Response category is defined as the provision of ALS1 services, as specified above, in the context of an emergency response.

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance provider begins as quickly as possible to take the steps necessary to respond to the call.

Advanced Life Support, Level 2 (ALS2)

Advanced life support, level 2 (ALS2) means either transportation by ground ambulance vehicle, medically necessary supplies and services, and at least three administrations of medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures:

(1) Manual defibrillation/cardioversion.
(2) Endotracheal intubation.
(3) Central venous line.
(4) Cardiac pacing.
(5) Chest decompression.
(6) Surgical airway.
(7) Intraosseous line.

Specialty Care Transport (SCT)

Specialty care transport (SCT) means interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

Paramedic Intercept

Paramedic intercept services are ALS services provided by an entity that does not provide the ambulance transport. Under a limited number of circumstances, Medicare payment may be made for these services. For a description of these circumstances and services see PM B-99-12 dated March 1999 and PM B-00-01 dated January 2000, both titled Paramedic Intercept Provisions of the BBA of 1997.

Fixed Wing Air Ambulance (FW)

The fixed wing air ambulance (airplane) category is services furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles (for example, heavy traffic), preclude such rapid delivery to the nearest appropriate facility by ground ambulance.

Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Rotary Wing Air Ambulance (RW)

The rotary wing air ambulance (helicopter) category is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, (for example, heavy traffic), preclude such rapid delivery to the nearest appropriate facility.

Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Physician Certification Statement

Neither the presence nor the absence of the signed physician certification statement necessarily proves (or disproves) whether the transport was medically necessary.

When a non-emergency transport is scheduled or unscheduled, the ambulance provider must obtain a written order from the patient's attending physician certifying that the medical necessity requirements are met.

Before submitting a claim the ambulance provider must:

1. Obtain a signed physician certification statement from the attending physician; or

2. If the ambulance provider is unable to obtain a signed physician certification statement from the attending physician, a signed physician certification must be obtained from either the physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner who is employed by the attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported and who has personal knowledge of the beneficiary's condition at the time the transport is ordered or the service was furnished; or

3. If the provider is unable to obtain the required statement as described in 1 and 2 above, within 21 calendar days following the date of service, the ambulance provider must document its attempts to obtain the physician certification statement and may then submit the claim. Documentation includes but is not limited to signed United States Postal Service forms verifying mail sent to the physician.

The provider must keep the appropriate documentation on file and, upon request, present it to the fiscal intermediary. It is important to note that the presence of the signed physician certification statement does not necessarily determine if the transport was medically necessary.

NON-EMERGENCY RESPONSE

Ambulance transportation is covered when it meets medical necessity requirements. Nonemergency transportation by ambulance is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion, nor a required criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations. For bed confinement, the following criteria must be met:

Bed confinement criteria is met when the beneficiary is:

1. **Unable to get up from bed without assistance**
2. **Unable to ambulate**
3. **Unable to sit in a chair or wheelchair**

1. The beneficiary is unable to get up from bed without assistance;
2. The beneficiary is unable to ambulate; and
3. The beneficiary is unable to sit in a chair or wheelchair.

All three of the above-listed components must be met in order for the patient to meet the requirements of the definition of "bed confined." The term applies to individuals who are unable to tolerate any activity out of bed. This term is not synonymous with "bed rest," "non-ambulatory," or "stretcher-bound."

Non-emergency services may be:

1. **Scheduled, repetitive,**
2. **Scheduled, non-repetitive, or**
3. **Unscheduled**

Some non-emergency services are scheduled. Scheduled may be repetitive or non-repetitive. **Repetitive scheduled** services are regularly provided transportation for the diagnosis or treatment of a patient's medical condition, e.g., transportation for dialysis. Repetitive, scheduled, non-emergency ambulance transports require the ambulance provider to obtain, before the transport, but no earlier than 60 days prior, a written order from the beneficiary's attending physician certifying that the coverage requirements are met.

Unscheduled services generally pertain to non-emergency transportation for medically necessary services; e.g., from one facility to another.

SPECIAL CIRCUMSTANCES

In the regulation for the ambulance fee schedule, Medicare policies for some circumstances were clarified.

Pronouncement of Death

The following information explains Medicare policy related to the death of a patient and the resultant effect on payment for any ambulance services under the ambulance fee schedule.

The death of a patient is recognized when the pronouncement of death is made by an individual legally authorized to do so by the State where the pronouncement is made. The following three scenarios that apply to

payment for ambulance services, ground or air,when the beneficiary dies:

1. If the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment may be made; however, neither mileage nor a rural adjustment would be paid.

   If a ground vehicle is dispatched, payment is made for a BLS service.

   If an air ambulance is dispatched, payment is made at the fixed wing or rotary wing base rate, as applicable.

2. Payment is made following the usual rules of payment (as if the beneficiary had not died) when:

   The beneficiary is pronounced dead after being loaded into the ambulance, regardless of whether the pronouncement is made during or subsequent to the transport.

   A determination of "dead on arrival" (DOA) is made at the facility to which the beneficiary is transported.

3. No payment will be made if the beneficiary was pronounced dead prior to the time the ambulance is called or dispatched.

Multiple Patients

An ambulance may transport more than one patient at a time, for instance, at the scene of a traffic accident. In this situation the payment should be prorated by the number of patients in the ambulance. If two patients are transported simultaneously, for each Medicare beneficiary, the payment allowance is equal to 75 percent of the allowed amount for the level of medically appropriate service furnished to the beneficiary. If three or more patients are transported simultaneously, then the payment allowance for the Medicare beneficiary (or each of them) is equal to 60 percent of the service payment allowance applicable for the level of care furnished to the beneficiary. However, a single payment allowance for mileage will continue to be prorated by the number of patients (Medicare and non-Medicare) onboard.

Multiple Arrivals

When multiple units respond to a call for services, the entity that provides the transport for the beneficiary should bill Medicare for all services furnished.

For example, BLS and ALS entities respond to a call and the BLS entity furnishes the transport after an ALS assessment is furnished. The EMT – Intermediate or Paramedic from the ALS service accompanies the patient to the hospital in the BLS ambulance. The BLS entity will bill using the ALS1 rate since an ALS service was furnished. Medicare will pay the BLS entity at the ALS1 rate. The ALS entity must look to theBLS entity for payment for its services.

Service Provided

Medicare pays only for the category of service provided and then only when the service is medically necessary, even if a local government requires an ALS response for all calls.

MEDICAL REVIEW OF AMBULANCE SERVICES

Claims will be reviewed in accordance with instructions in the Program Integrity Manual, Section 83-6-12. However, additional factors must also be taken into consideration based on the ambulance fee schedule and Program Memorandum AB-99-83.

Medical Review

Other methods contraindicated

Ambulance services are reviewed to determine if they met the ambulance coverage criteria. A determination is made as to whether the patient's condition was such that another method of transportation was contraindicated. Medically necessary transport by ambulance may include:

1. Emergency situations, (for example, accidents, injury, acute illness),
2. Need for restraints,
3. Unconsciousness or shock,
4. Requiring emergency treatment during the trip
5. Requiring immobilization, i.e., fracture or the possibility of a fracture,

6. Sustained acute stroke or myocardial infarction, or
7. Experiencing severe hemorrhage

Please note this list is not all-inclusive.

Review Under Fee Schedule

1. **Category of Service**
2. **Non-emergency Transport**

REVIEW CONSIDERATIONS RELATED TO THE AMBULANCE FEE SCHEDULE

Because of the ambulance fee schedule billing requirements, additional factors must be taken into consideration during the medical review process.

Category of Service

The documentation will be reviewed to determine if the category of service billed to Medicare is the category of service that was provided, and that it was the category of service that was medically necessary.

Non-Emergency Transports

Bed confinement criteria is met when the beneficiary is:

7. **Unable to get up from bed without assistance**
8. **Unable to ambulate**
9. **Unable to sit in a chair or wheelchair**

Ambulance transportation is covered when it meets medical necessity requirements described above. Nonemergency transportation by ambulance is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion, nor a required criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations. For bed confinement, the following criteria must be met:

Bed confinement criteria is met when the beneficiary is:

4. **Unable to get up from bed without assistance**
5. **Unable to ambulate**
6. **Unable to sit in a chair or wheelchair**

4. The beneficiary is unable to get up from bed without assistance;
5. The beneficiary is unable to ambulate; and
6. The beneficiary is unable to sit in a chair or wheelchair.

All three of the above-listed components must be met in order for the patient to meet the requirements of the definition of “bed confined.” The term applies to individuals who are unable to tolerate any activity out of bed. This term

is not synonymous with “bed rest,” “non-ambulatory,” or “stretcher-bound.”

Non-emergency services may be:

4. Scheduled, repetitive,
5. Scheduled, non-repetitive, or
6. Unscheduled

Some non-emergency services are scheduled. Scheduled may be repetitive or non-repetitive. **Repetitive scheduled** services are regularly provided transportation for the diagnosis or treatment of a patient’s medical condition, e.g., transportation for dialysis. Repetitive, scheduled, non-emergency ambulance transports require the ambulance provider to obtain, before the transport, but no earlier than 60 days prior, a written order from the beneficiary’s attending physician certifying that the coverage requirements are met.

Unscheduled services generally pertain to non-emergency transportation for medically necessary services; e.g., from one facility to another.